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Issue Date: 16 October 2003

In the Matter of	:	
	:	
Margaret Stoner,	:	**Case Nos.**: 2001-LHC-2027
Claimant	:	2002-LHC-2503
	:	2002-LHC-2504
v.	:	2002-LHC-2505
	:	
United States Marine Corps, MCCS,	:	**OWCP Nos.**: 06-181570
and Commandant of Marine Corps,	:	06-184722
Employer/Carrier	:	06-184723
	:	06-184724
and	:	
	:	
Director, Office of Workers'	:	
Compensation Programs,	:	
Party-In-Interest	:	

APPEARANCES:

Daniel F. Read, Esq.
For the Claimant

James Mesnard, Esq.
For the Employer

BEFORE:

Linda S. Chapman
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding involves claims for benefits under the Longshore and Harbor Worker's Compensation Act, as amended, 33 USC § 901, *et seq.*, as incorporated by the Nonappropriated

Fund Instrumentalities Act, 5 U.S.C. § 8171, *et seq.* (hereinafter collectively "the Act").[1] A hearing was held before me in Wilmington, North Carolina, on October 8, 2002, at which time the parties were given the opportunity to offer testimony and documentary evidence, and to make oral argument. At the hearing, I admitted Claimant's Exhibits 1 through 10, Employer's Exhibits 1 through 50, and Administrative Law Judge's Exhibits 1 through 10 into evidence. Claimant's Exhibit 11[2] which is Dr. Michael Nunn's deposition transcript, and Employer's Exhibit 51, which is Dr. Leonard Nelson's deposition transcript, were admitted post-hearing.[3] The Claimant's post-hearing brief was filed on May 29, 2003; and the Employer's post-hearing brief was filed on May 30, 2003. The Director submitted argument regarding the Employer's request for Section 8(f) relief on May 20, 2003. I have reviewed and considered these briefs in making my determination in this matter.[4]

I. Statement of the Case

The Claimant's Testimony

The Claimant, Margaret Anne "Peggy" Stoner, is 45 years of age, and worked as a civilian employee of the United States Marine Corps/Marine Corps Community Service (M.C.C.S.) beginning in July of 1976**.** (Tr. 19-20). She worked as a floater in the P.X., a cashier in the Seven Day Department, and a salesperson in the Sight and Sound Department.. (EX 25 at pp. 3-6). In 1990, she began working as a vending machine attendant in the Vending Department. (Tr. 20; EX 25 at p. 7). Her last regular job with the M.C.C.S. was in the money room of the Vending Department from December of 1999 through June of 2000. (Tr. 21, 42).

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[1] There are four separate claims involved. The claims were consolidated by Order dated August 23, 2002 for purposes of hearing and decision.

[2] In my Order Closing Record and Setting Briefing Schedule dated April 23, 2003, I marked Dr. Nunn's deposition transcript as Claimant's Exhibit 10. At the hearing, I marked a statement made by Claimant's witness, Mr. Bradley Slater, as Claimant's Exhibit 10. For purposes of correcting this error, Dr. Nunn's deposition transcript will be marked as Claimant's Exhibit 11.

[3] On March 6, 2003, the Claimant's counsel Dr. Nunn's submitted follow-up notes for the period of October 2002 through February 2003, and asked that they be included in the record. Although Dr. Nunn's deposition was taken on March 11, 2003, it does not appear that counsel attached these notes as exhibits to the deposition. No objection was lodged by the Employer to the admission of these exhibits, and the Employer had the opportunity to cross-examine Dr. Nunn at his deposition. Accordingly, I will consider these records to be attachments to Dr. Nunn's March 11, 2003 deposition.

[4] References to the record are as follows: "Tr." for transcript; "CX" for Claimant's Exhibits; "EX" for Employer's Exhibits; and "ALJ" for Administrative Law Judge's Exhibits.

As a vending machine attendant, Ms. Stoner's job entailed refilling vending machines located in various buildings at the Cherry Point Marine Corps Air Station. (Tr. 21; EX 1). Her route consisted only of snack machines. She stocked the machines with items such as candy, gum, chips, crackers, pastries and other lunch snacks. She did not refill drink machines. (Tr. 22, 23). She had a route that she would complete each day; however, that route varied each day with her largest route encompassing no more than eight miles. (Tr. 21; EX 25 at p. 8). Typically, Ms. Stoner would service between ten and fifteen machines a day. (Tr. 21, 22). Ms. Stoner's workday typically began at 2:00 a.m., and she would work eight hours a day, five days a week. The first six hours of her workday were used to complete her route. Once her route was completed, she would return to her shop and turn the money she collected from the vending machines in, clean her truck and load it for the next day, and get the paperwork ready for the next day. (Tr. 21, 24).

The job of vending machine attendant required physical labor, including climbing in and out of her vehicle and climbing stairs occasionally, lifting a tow dolly and loading it into a vehicle and removing it from the vehicle, lifting boxes of merchandise onto a tow dolly, pulling the tow dolly, and bending and kneeling. (Tr. 23).

Ms. Stoner claims that she sustained three work related injuries.[5] The first allegedly occurred on August 13, 1998. On that day, the Claimant testified that she was servicing Building 245, a two story paint hangar with an elevator. On this day, the elevator was out of order, so she had to haul her merchandise up two flights of stairs, approximately ten to fifteen steps, to the second floor. She hauled her merchandise using a tow dolly which weighed approximately thirty-five to fifty pounds, and which was loaded with no less than six boxes of merchandise. The products she used to stock the single snack machine in Building 245 consisted of a case of candy, two boxes of chips, two boxes of pastries, and a case of cheese crackers. (Tr. 27-28, 76-78). She filled the snack machine and began the walk back down the stairs with her tow dolly and about one-quarter of the merchandise she used to fill the snack machine. She experienced a little bit of soreness in her lower back, but it was not enough to stop her from working. She finished her work for the day, and went home and sat in a chair, where she had a charley horse in her right leg. The pain radiated from her lower back and went down her right leg. (Tr. 29, 82).

Over the next couple of days, the Claimant experienced pain, but still went to work. She only worked a couple of hours each of the next few days, before stopping because of the pain. The pain became unbearable, so she went to the doctor and was out of work for two weeks. There is some dispute over whether Ms. Stoner informed her supervisor of the injury before she went out of work for the two weeks. The Claimant testified that at some point she informed a supervisor that she would be out of work for two weeks as a result of her injury. She continued to experience pain, and received a steroid injection in her right hip on August 25, 1998. The injection made her better, and she resumed her regular work duties. She was able to work for six

[5] The Claimant originally alleged four separate injuries. As discussed later, however, it appears that there are only three injuries at issue.

months before again having to stop work because of the pain. She received another steroid injection in March of 1999. (Tr. 29-32, 82-85).

The Claimant alleges that the second injury occurred on May 19, 1999, when she was again servicing Building 245. The elevator was out of order again, so she was left with the prospect of having to climb two flights of stairs with her tow dolly loaded with merchandise. She received the aid of the workers in the building, who carried the tow dolly with merchandise up two flights of stairs. She then serviced the snack machine. Unable to recruit anyone to assist with her descent down the stairs, she had to descend two flights of stairs with the tow dolly and remaining merchandise unassisted. When she reached the bottom of the stairs she felt a sharp, severe, burning, and stabbing pain in her back. She loaded her truck, went back to her office, reported the incident to her boss and went to the Occupational Health Clinic. (Tr. 32-34; EX 2, 3, 15). As a result of the injury, Ms. Stoner was out of work until June 1, 1999.

Upon her return to work, Ms. Stoner was placed on light duty. She received the assistance of a co-worker, who was responsible for all the lifting; she was responsible for filling the vending machines and collecting the money. This arrangement lasted only one day, however, because the co-worker assigned to assist her was reassigned to work with another co-worker. Thereafter, she returned to her regular duties. As a result of having to lift the merchandise, she continued to have back pains which precluded her from completing a full day's work. (Tr. 34-38). Eventually she ceased working in August of 1999, and returned on October 4, 1999. When she returned to work, she worked with the assistance of a co-worker until December. She had to stop working again because climbing and standing became too much for her, and she could not do her job anymore. (Tr. 38-41).

Eventually, Ms. Stoner was re-assigned to a position in the money office, performing light duty. In this position, Ms. Stoner straightened and sorted the money that was removed from the vending machines. With the exception of having a sore back that did not prevent her from sitting, she performed this job without incident until June of 2000. (Tr. 41-42)[6]

The final work-related injury allegedly occurred on June 20, 2000.[7] She was asked by her supervisor to empty a vending machine. She placed the items on a flat bed cart and proceeded to push the cart to the warehouse. Upon arriving at the warehouse, she experienced a neck spasm, causing her to be out of work on June 21; she was seen by her doctor on June 22, 2000. She was again out of work on June 23, 2000, because she experienced pain in her left leg. She explained

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[6] The Claimant testified at her deposition that she reinjured her back on June 6, 2000, lifting coins, and that she was assigned to answer the phone.

[7] According to Claimant's Pre-Hearing Submission dated March 18, 2002, the Office of Workers' Compensation Programs lists a date of injury as June 1, 1999 among the claims brought by the Claimant. This, according to Claimant's counsel, is an administrative error. At the hearing, Claimant did not proffer any evidence of a work-related injury on June 1, 1999.

that it felt like her leg was jammed into her hip. (Tr. 47). She was eventually kept out of work by her doctor from late June until the middle of July.[8] (Tr. 48).

After her August 1998 injury, Ms. Stoner received treatment from Dr. Michael Gray at the Carteret Urgent Care Center. Since August 1, 2000, Ms. Stoner has been seen by Drs. Bob Pettis, Ralph Delaney, Leonard Nelson and Michael Nunn, as well as a physical therapist. She stopped seeing Dr. Nunn in August 2001 because his bill had not been paid, and he would not see her. However, her health insurance subsequently paid Dr. Nunn, and she made the co-payments; she expects to see Dr. Nunn again.[9]

At her deposition, the Claimant testified that in January 2001 she tried to find employment, as required by the unemployment compensation service (EX 25 at 42, 43).

Mr. Bradley Slater

Mr. Slater was a co-worker of the Claimant. He was employed as a warehouseman and worked with her for several years, in particular, during the period around her May 19, 1999 back injury. (Tr. 110, 113). As a warehouseman, he controlled the merchandise the route people used to stock the vending machines, and assisted the route people in loading their trucks with the merchandise. (Tr. 110). He saw the Claimant daily, sometimes twice a day. (Tr. 111). Mr. Slater testified that before the Claimant's May 19, 1999 injury, he had not heard her mention having back pain or noticed that she was having trouble walking. (Tr. 111, 113).

Mr. Slater testified that on May 19, 1999, the Claimant mentioned hurting her back; this hindered her ability to walk and lift things. (Tr. 113). He also noted that the Claimant began walking sideways in a crab-like fashion. When the Claimant relocated to the money room, Mr. Slater periodically assisted her with lifting money bags. (Tr. 113-114).

Mr. Guy Warren

Mr. Warren was a co-worker of the Claimant. Like the Claimant, Mr. Warren worked as a vending machine attendant. (Tr. 125). Mr. Warren testified that before the Claimant's back injury in May of 1999, he did not see her often, because she began her workday earlier than he did. (Tr. 126). In June of 1999, Mr. Warren was assigned to assist the Claimant. Specifically, his job was to carry all of the Claimant's merchandise to the vending machines. He did all of the lifting. This arrangement did not last long because he was reassigned to another co-worker who required assistance. (Tr. 127-128).

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[8] The vending operations were contracted out, and thus the Claimant's job abolished, in August 2000.

[9] In fact, Dr. Nunn has resumed treating the Claimant.

Ms. Patricia Debar

Ms. Debar is a neighbor of the Claimant. (Tr. 138-139). She also worked as a supervisor of the Claimant when she worked in the Sight and Sound department in the early 1980's, and later in the 1988, when Ms. Debar was in the Operations Department. (Tr. 139, 140). At the time the vending operations were contracted out, Ms. Debar worked as a contracting officer. She testified that if a worker in the vending section had difficulty walking or lifting, they were normally placed on light duty. Typically, this involved working behind a desk, and excluded any manual labor. There were not a lot of these positions for a person working in vending, because a position in vending is considered a manual labor job. (Tr. 143-144).

Video Surveillance

Employer's counsel submitted video surveillance film footage of the Claimant, taken on January 23, 2002 and January 25, 2002. On January 23, 2002, Claimant was filmed running several errands. She can be seen leaving a bank and loading groceries into her van. The Claimant can also be seen bending down in front of her van and climbing into it. She does not appear to experience any difficulty with either loading the groceries into the van or climbing into the van. Neither does the Claimant appear to limp while walking.

On January 25, 2002, the Claimant was again filmed running errands. She does not appear to experience any difficulty climbing into the van. The film does capture moments in which Claimant limps noticeably, but at other times she walks without a limp.

At the formal hearing, the Claimant questioned whether she was in fact the individual captured on the surveillance film. (Tr. 60, 74-75). She also questioned if in fact the van seen in the film was hers, because the license plate could not be seen. (Tr. 60). In fact, the license plate appears in several spots on the video and is clearly visible.

Cherry Point Naval Hospital

The exhibit file includes records from the Cherry Point Naval Hospital in North Carolina (EX 14, 15). The Claimant was treated at the emergency room on February 23, 1985 for a lumbar strain. On July 23, 1991, she presented at the hospital for an injury to her left thigh, suffered after boxes fell off a heavy cart that she was pulling. She was also treated in 1995 for burns to her fingertips, and a cut finger. Finally, on May 19, 1999, she presented for treatment for pain in her lower back and right leg, suffered after she went down stairs with a dolly. An x-ray performed in connection with that injury showed no evidence of fracture or subluxation; all disc spaces were intact. There were no arthritic changes, and the sacroiliac joints were unremarkable.

Dr. Michael Gray/Helen Vickers, FNP

The Claimant has also been treated at the Carteret Urgent Care Center, where she was

seen by Dr. Michael Gray on a number of occasions beginning in August of 1998 (EX 16). On her initial visit, the Claimant was seen by Dr. William Perry. She complained of a pulled muscle in her right thigh, which was painful with heavy pulling and going downstairs with a dolly. Thereafter, Claimant was treated by Dr. Gray and Ms. Helen Vickers, a nurse practitioner, for low back pain and right hip pain. The Claimant's diagnosis was lumbosacral strain, and she was advised to use over the counter Advil and do home exercises; at one point, she was prescribed prescription pain medication. By August 31, 1998, the notes indicate that she had decreased tenderness and no spasm, and that her lumbosacral strain had resolved.

The Claimant was treated again beginning in July 1999 for sciatic nerve problems and lumbosacral strain; she was prescribed pain medication, and advised to do home exercises and use ice. An MRI performed in February 2000 showed no protrusion or extrusion of a disc that would explain the Claimant's clinical symptoms; there was mild to moderate facet arthropathy on the right at L5/S1, which was thought could be the etiology for her symptoms. The Claimant continued to be treated with pain medication; she also received a steroid injection, and was prescribed physical therapy.

The Claimant reported on June 22, 2000, that she had experienced pain in her neck to her shoulder while pushing a cart at work. She was diagnosed with exacerbation of lumbosacral strain. At a visit on July 22, 2000, the Claimant reported that she experienced sharp lower back pain when she picked up $480 in quarters at work. She was diagnosed with exacerbation of her lumbosacral strain, and her medications were continued.

Ms. Vickers wrote a letter on January 19, 2001, indicating that the Claimant, due to a chronic back condition was not to lift more than 25 pounds, bend, twist, or stoop. She was not to climb ladders, and was to avoid repetitive stair climbing. Ms. Vickers felt that the Claimant would be best suited for a seated job.[10]

Family Medical Care

The Claimant began chiropractic treatment at the Family Medical Care group in July 1999 (EX 17). She indicated that she was suffering from lower back pain and sciatic nerve pain, which had begun on July 15. An x-ray performed on July 26, 1999 showed facet arthrosis at L4/L5 and L5/S1, and spondylosis at L3 and L4, and the thoracolumbar junction. Dermatomal evoked potential studies of the lower extremities, done on August 6, 1999, were abnormal, with findings indicative of abnormal neuropathic changes, consistent with nerve root dysfunction at L4, L5, and S1 bilaterally. The Claimant was released to return to work as of August 2, 1999.

The Claimant underwent a lower nerve conduction study on August 2, 1999, at the request of Dr. Pettis (CX 4). The study was abnormal, with findings indicative of abnormal motor

[10] According to the Claimant, Ms. Vickers has left Dr. Gray's office, and now works on her own.

and sensory neuropathic changes consistent with peripheral neuropathy.

The Claimant returned for treatment of low back pain on several occasions, and was advised not to return to work until September 24. On September 27, Dr. Pettis indicated that she would not be able to return to work for two to four weeks. After her visit on October 29, the Claimant was released to return to work. However, on December 3, she was kept out of work until December 6, with restrictions on climbing. Subsequently, Dr. Pettis indicated that she could not perform her regular work of vending machine attendant, but could perform light duty work, with restrictions.

Carolina Rehabilitation and Evaluation Center

The record includes notes from the Carolina Rehabilitation and Evaluation Center (CX 2). The physician is listed as Helen Vickers, FNP (formerly with Dr. Gray at Carteret). Ms. Vickers assessed her with low back pain with radicular symptoms, pain with palpation in the right lower back and buttock, lowered endurance for advicities of daily living and work, and lowered lumber spinal stabilization. The Claimant underwent ten physical therapy treatments, but was discharged due to her pain.

Dr. Michael K. Nunn

The Claimant first visited Dr. Nunn, of the Community Wellness Center, on August 23, 2000 (EX 20). She reported to Dr. Nunn that in May 1999 she felt a sharp pain in her lumbar region while going down a flight of steps. She had increased pain, and was unable to work. When she did return to work in August 2000, she was unable to perform her vendor duties, and she was fired.[11]

On examination of the Claimant, Dr. Nunn noted that she had severe pain and spasm in the lumbar region, with hyperlordosis of the lumbar spine. Her pain and spasm extended to the mid-thoracic region. He noted that the piriformis was also contracted bilaterally. Dr. Nunn's impression was lumbar pain, status post chronic strain with associated muscle spasm, and sciatica bilaterally. He started the Claimant in chronic pain management therapy. She continued to see Dr. Nunn through August 2002 (EX 20, CX 9). At that time, Dr. Nunn refused to see the Claimant, because his bill had not been paid. Subsequently, the Claimant's health insurance has paid Dr. Nunn, and the Claimant has paid him the co-pay amounts.

Dr. Nunn completed a form in connection with the Claimant's Social Security Disability claim, dated April 23, 2002 (CX 9). He indicated that she could lift or carry less than ten pounds, could only walk less than two hours in an eight hour day, could sit less than six hours in an eight hour day, and was limited in pushing and pulling. She could never climb, balance, kneel, crouch,

[11] In August 2000, the vending operations were contracted out, and the Claimant's job was abolished.

crawl, or stoop. Dr. Nunn indicated that the Claimant "may not work."

The Claimant resumed treatment with Dr. Nunn in October 2002. Dr. Nunn continued to perform myofascial technique, and to prescribe medication and electrical stimulation. There is no indication of any objective testing. While the notes indicate that the Claimant was doing well with pain control, Dr. Nunn also stated in the October 1, 2002 note that her pain was work related, and she was unemployable. He also discussed her mental status, although there is no indication that any psychological testing was performed.

Dr. Nunn testified by deposition on March 11, 2002 (CX 11). He testified that he is licensed as a doctor of psychiatry and doctor of osteopathy. He described osteopathy as the practice of holistic medicine, specializing in chronic pain and injuries to the musculoskeletal system. He testified that over the two and a half years that he treated the Claimant, she suffered from depression, and at times had delusional material associated with her pain and medications. In his opinion, the Claimant has a musculoskeletal injury to the lumbar region, a permanent myofascial injury. She will continue to have chronic pain, and will have episodes where she will not be able to walk well. She is doing the best that she will be able to do, with chronic pain management and treatment. He also diagnosed her with major depression, although he is not treating that for her.

In support of his diagnosis, Dr. Nunn stated that the Claimant has an ambulatory dysfunction, and spasm in the lumbar region. She has used heat for so long that her skin is burned and mottled. He stated that her muscles in the lumbar region spasmed due to strain from trauma, in an attempt to protect the vertebrae. He felt that his observations of the Claimant were consistent with the small lateral disc herniation shown on the February 2002 MRI.

According to Dr. Nunn, there is a direct relationship between the incidents of August 13, 1998 and May 19, 1999, and the Claimant's chronic back changes. He indicated that she had suffered trauma, and her body attempted to correct it with muscle spasms, which make it difficult for her to walk. She has been injured in the muscles and fascia of her lumbar spine, and the injury is spreading into the pelvic area, where she is developing sciatica. He felt that her psychiatric condition was the result of her pain, and that there was not sufficient conflict in her personal and family life to have resulted in her depression.

Dr. Nunn stated that the Claimant is not able to work, due to her pain and her lumbar spine. She cannot do any lifting or bending, and cannot sit for any length of time. He does not believe that this condition will change, and the best that can be done is to help her with her quality of life and teach her how to deal with chronic pain. He currently sees the Claimant every two weeks, and performs "full body myofascial technique," which involves massage physiotherapy to loosen her up, and manipulation of her muscles. He described the treatment by osteopaths as similar to that of chiropractors, with osteopaths having eight or ten different styles, as opposed to just a few.

Dr. Nunn was not aware that there was acrimony between the Claimant and her brother over their father's estate, or that her job was abolished in August 2000. He felt that if there were jobs identified that conformed with his restrictions, the Claimant could try them, but they would have to be "not very cognitive impairing."

Dr. John T. Langley

Dr. Langley saw the Claimant on May 4, 2000, at the request of the Employer (EX 21). He noted that the Claimant had begun having episodes of low back pain about fifteen years earlier, and on May 19, 1999, she experienced acute back pain while carrying merchandise down the stairs in her job as a vending machine attendant. The Claimant told him that she was in bed for three months, and was able to return to work, although not to her regular work. The Claimant was treated with pain medication, injections, muscle relaxants, and aspirin and anti-inflammatory medication, which helped somewhat. An MRI performed the previous February was normal.

On examination of the Claimant, Dr. Langley noted that she cooperated quite poorly with motor testing. Her gait and heel and toe walking were satisfactory, although done quite slowly. The Claimant was able to squat and rise, but moved quite slowly. There was normal range of low back motion, with subjective tenderness over the lumbar muscles. There was no muscle spasm or spine tenderness. The straight leg raising and tibial nerve signs were negative. The Claimant's leg lengths were equal, and there was no atrophy. Dr. Langley found no sensory, motor, pulse, or reflex deficit of the lower extremities. He noted normal painless range of hip, knee, ankle, and foot motion bilaterally.

Dr. Langley's diagnosis was chronic lumbosacral strain and obesity. In Dr. Langley's opinion, the Claimant's condition was not the result of an injury on May 19, 1999, and he felt that she had reached maximum medical improvement. He felt that she would need continued conservative support for her depression and chronic back pain, but that she had no objective evidence of impairment that would prevent her from returning to work at full duty. He felt that rehabilitation of the Claimant would be extremely difficult. He indicated that she seemed happy with her restricted work of limited lifting, and in spite of no objective findings, it probably would be necessary to continue with such work restrictions. He anticipated only conservative future medical treatment, based on the total lack of objective findings.

Dr. Christopher S. Delaney

Dr. Delaney saw the Claimant on July 25, 2000 (EX 37). The Complainant's complaint was low back pain and pain in her right buttocks, which she associated with an event in 1998, when she was sitting in a chair at home and noted a sudden onset of pain in her right leg. She also reported a long history including events at work starting in May 1999, which resulted in low back sprain.

On examination of the Claimant, Dr. Delaney noted symmetrical muscle development,

with no evidence of disuse atrophy. There was no acute joint inflammation, limb length discrepancy, or pelvic malalignment. Her spinal curves were all normal, and her range of motion was within functional limits across all major pivots. There was no paraspinal araceous tenderness, and sensation was normal to soft touch in all dermatomes. The Claimant's strength was normal in all key muscle groups. The reflexes were symmetrical, although with percussion the Claimant's whole body jumped in spasms until cued otherwise. The flip test and straight raise sign, and axial compression test, were negative. The end block rotation test was positive, with rotation to the right but not the left.

Dr. Delaney felt that the Claimant's MRI results, and his physical examination, did not suggest any specific neurologic dysfunction, and he did not see any evidence of disc herniation or significant arthritis, although there was some evidence of chronic degenerative changes, which he did not associate with trauma. He concluded that the Claimant had a chronic pain syndrome without associated anatomic abnormality. He felt that it was appropriate for her to return to work on an as tolerated basis.

Dr. Leonard D. Nelson, Jr.

Dr. Nelson examined the Claimant at the request of the Employer on December 12, 2001 (EX 22). He noted her long history of back and right leg pain since May 1999, although there was some documentation of pain in 1998. On examination of the Claimant, Dr. Nelson noted that she got up very gingerly from the examining table, and walked very slowly; simple touching of her skin on the lower back caused her to jump and move around. He noted that seated, she appeared to possibly have a straight leg raise on the right, but that she jumped fairly dramatically to almost any movement in her lower extremities or touching of her skin. He noted that her internal and external rotation of the hips appeared to be normal. Her reflexes were difficult to ascertain due to her reactions, but they appeared to be possibly hyper on the right, and normal on the left. She was otherwise neurologically intact to strength. The Claimant brought a 1999 x-ray, which was normal.

Dr. Nelson's impression was back and right leg pain, possibly radicular in nature; and positive straight leg raise and exaggerated pain response to numerous maneuvers by physical examination. Based on the office notes he reviewed, Dr. Nelson felt that the Claimant had a problem with her back and right hip pain before her on the job injury. He felt that she did not have any long term residual impairment, but required work restrictions, which could be documented by a FCE. He felt that she needed further medical care, including an MRI and possible discography.

The Claimant underwent an FCE on February 21, 2002 (EX 26). The results were invalid, due to evidence of inconsistent and sub-maximum effort, without physiological behavior. The report indicates that the Claimant had positive inappropriate illness behavior, and positive symptom magnification. It was recommended that she return to work with restrictions, with a gradual return to regular duty over a two to four week period. The evaluator indicated that the

Claimant would be a candidate for work conditioning, but the prognosis for improvement was poor, due to her poor effort and possible symptom magnification during testing. The Claimant showed significant limitation in repetitive movements and material handling, and gave limited effort on all tests, with reports of severe pain. Inconsistencies were noted in the Claimant's gait pattern and range of motion, suggesting non-organic symptoms. Because of the invalid results, it was recommended that portions of the FCE be repeated. The test results indicated the least that the Claimant could safely perform, but it was not recommended that these results be used to set permanent restrictions.

The Claimant also underwent a lumbar spine MRI on February 21, 2002 (EX 28). It showed degenerative disc and facet disease in the lower lumbar region, and a small lateral disc herniation on the right at L3/L4, within the neural exit foramen.

The Claimant underwent a discogram on March 18, 2002 (EX 43). The injections at L3/L4 and L4/L5 produced a significant increase in the Claimant's pain; the L4/L5 injection produced typical radiation into the right hip.

Dr. Nelson testified by deposition on October 22, 2002 (EX 51). He discussed the results of his examination of the Claimant on December 12, 2001, noting that she had very marked mood swings, at times laughing, and at times crying. He stated that she got up from the examination table very gingerly and slowly, and simply touching her skin in the lower back made her jump and move around. According to Dr. Nelson, this was a little bit exaggerated from what he viewed as normal. Her reflexes were normal, and she was neurologically intact, yet she jumped fairly dramatically to almost any movement of her lower extremities or touching of her skin.

The only objective finding, according to Dr. Nelson, was a slightly positive straight leg raise on the right, but that was equivocal. He described this test as very accurate at predicting a pinched nerve in the back. If a nerve is pinched in the lower back, the test should produce a lot of pain. With the Claimant, it did not; although Dr. Nelson thought that something might possibly be going on, it was difficult to say, due to her other hyperreactive reactions. He noted that the functional capacity evaluation showed very inconsistent effort, submaximal effort inappropriate to illness behavior, and symptom magnification, which are signs that she was not trying very hard, or maybe even "faking it." He noted that the discogram showed that the Claimant could have pain originating from L3/L4 or L4/L5, but in light of the whole picture, these results were not significant enough to act upon. He noted that the MRI showed degenerative disc and facet disease in the lower back, or in layman's terms, arthritis, which is the cause of any long term back pain suffered by the Claimant. He felt that the small lateral disc herniation at L3/L4 on the right, based on her symptoms and physical examination, was insignificant. He stated that it did not correlate to her symptoms, as such a herniation would produce pain in the front of the right thigh. Yet the Claimant indicated that she did not have pain in the front of her legs. She had pain in her lower back, and going down both her legs in a nonspecific way, which is inconsistent with such a disc herniation.

Dr. Nelson felt that the dermatomal evoked potential tests performed by Dr. Nunn showed peripheral neuropathy that was not of spinal origin, as it was bilateral instead of one-sided. According to Dr. Nelson, these studies are not well-accepted in the medical community, and are not used as a basis for surgery or treatment.

Dr. Nelson felt that the Claimant was able to work, although she needed to undergo an FCE with valid consistent effort. He noted that in the worst-case scenario, the work restrictions from the previous FCE could be used.

Dr. Robert Rollins

Mr. Rollins is a forensic psychiatrist who testified at the hearing (Tr. 161). He described forensic psychiatry as a subspecialty of psychiatry, dealing with the application of psychiatric knowledge to legal issues. He is also certified in pain medicine, and is an independent medical examiner.

Dr. Rollins saw the Claimant on February 23, 2002, at the request of the Employer, and reviewed her medical records (EX 27). The Claimant indicated that she had discontinued all medication five days earlier, but she declined to discuss this with Dr. Rollins. She was no longer being treated, and she did not identify any medical caregivers. The Claimant reported that she had pain in her low back, moving into the right hip and calf, made worse by rain or cold. According to the Claimant, her pain is usually 8.5 on a scale of ten, never less than 7. Activity causes spasm from the bottom of her feet, into her legs and arms.

Dr. Rollins' assessment was that the Claimant suffers from bereavement related to the loss of her parents and loss of relationships. Alternatively, this could be diagnosed as depressive disorder NOS; her symptom complex could also be viewed as a pain disorder with psychological factors. It was his opinion that her psychiatric disorder did not result from the 1999 or 2000 injuries. He noted that the Claimant was able to carry out the activities of daily living, and that there were jobs she could do. He recommended a treatment and rehabilitation program of antidepressant medication, increasing activity, decreasing isolation, counseling, vocational evaluation, and possible retraining. He indicated that the Claimant had no psychiatric work restrictions.

In an addendum dated September 25, 2002, Dr. Rollins attached the DSM IV criteria for the diagnosis of pain disorder associated with psychological factors, which states that psychological factors are judged to have the major role in onset, severity, exacerbation, or maintenance of pain (EX 50). In Dr. Rollins' view, psychological factors cause the Claimant depression and pain, and serve to remove her from the stress of normal work. He noted that both Dr. Langley and Dr. Nelson reported that symptoms exceeded objective findings. In his opinion, the Claimant's psychiatric symptoms are not the result of work injuries in 1998, 1999, or 2000, but relate to the loss of her parents, dependency, and secondary gain. He felt that her psychiatric impairment does not prevent her from performing the jobs of janitor, office assistant, sales

representative, store manager, assistant manager, and courier/messenger.

At the hearing, Dr. Rollins testified that from a psychiatric perspective, the Claimant can work, although she may need vocational assessment and perhaps counseling and retraining. As far as the Claimant's physical ability to work, Dr. Rollins deferred to the two orthopedic examinations and the functional capacity evaluation; nothing in his review of Dr. Nunn's records changed his views (Tr. 165).

According to Dr. Rollins, the Claimant perceives herself as not being able to work, and Dr. Nunn has told her that she is not able to work. Dr. Rollins stated that the Claimant's mental status examination was essentially normal, and from a psychiatric viewpoint, she is able to carry out the activities of daily living. Dr. Rollins believed that she has the mental ability to work. He acknowledged that the Claimant claimed that she is in too much pain to work, but he noted that pain in subjective, and there was no way of measuring that, or knowing how much pain the Claimant has. He did note that the rehabilitation approach with chronic pain is to increase function, even though pain may persist. He pointed out that the two orthopedic examinations indicated that physically the Claimant was able to work (Tr. 166). He also felt that the Claimant would benefit by increased activity, of which work would be a part.

Dr. Rollins testified that in his opinion, the Claimant's psychological problems were not caused by her employment, but come from other causes (Tr. 167). He stated that the psychological testing he conducted showed that she has a lot of psychological distress, caused by the break up of relationships, loss of her parents, and conflict in her family. He believes that these are the causes of her psychological distress. He viewed her problem as bereavement, related to the loss of her parents and the loss of relationships. Her problems could also be diagnosed as depression, with her pain complex viewed as pain disorder with psychological factors. This is a diagnosis in which psychiatric issues are significant in terms of the onset and maintenance of pain (Tr. 168). He stated: "It would be my view that the pain she's experiencing is caused by nonorganic factors and serve the purpose of protecting her from the demands of every day life" (Tr. 171).

Barbara K. Byers

Ms. Byers is a vocational rehabilitation counselor hired by the Employer who completed a vocational evaluation and labor market survey to identify employment options for the Claimant (Tr. 177-178). She spoke with the Claimant several times on the telephone, but never actually met her.[12]

[12] Ms. Byers testified that they had scheduled an appointment, but Ms. Byers had to cancel it because of the death of a friend. They had a telephone interview on February 22, 2002, and Ms. Byers asked to meet with the Claimant; the Claimant told Ms. Byers that she would call to confirm. Ms. Byers called the Claimant twice on March 12, when she was in Jacksonville, but the Claimant did not answer, so Ms. Byers left a message. Ms. Byers tried again to schedule an

On March 7, 2002, Ms. Byers sent the Claimant a letter identifying five positions that were available to her, and were within the work restrictions as set out in the FCE (EX 30). They included manager, assistant manager, janitor, sales associate, and office assistant. On March 11, 2002, Ms. Byers forwarded three additional positions, sales assistant, office assistant, and messenger (EX 31).

Ms. Byers prepared a labor market survey report dated March 14, 2002 (EX 35). She noted that she had made several attempts to meet with the Claimant for a vocational evaluation and testing, but had been unable to do so. In completing her report, she reviewed medical records from Dr. Langley, Dr. Nelson, Dr. Gray, and Dr. Nunn, as well as the Claimant's answers to the Employer's interrogatories. Ms. Byers noted that the Claimant has a 12th grade education, and an extensive work history as a cashier, sales person, and customer service worker. Based on her work history, education, and physical capabilities, Ms. Byers felt that she qualified for a variety of positions available in the labor market. She identified a number of jobs with employers who indicated that they would consider the Claimant as a qualified applicant, and she notified the Claimant of the positions by mail. Ms. Byers also contacted the employers again, to determine if the Claimant had applied for the positions; she did not (Tr. 185). Based on her labor market survey, Ms. Byers felt that the Claimant had a wage earning capacity of $7.50 to $10.00 an hour.

Ms. Byers forwarded the job descriptions to Dr. Nelson on March 15, 2002, and asked him to review them to see if they were within the Claimant's physical capabilities, or if modifications were needed to perform the jobs (EX 39). Dr. Nelson returned the descriptions, approving the jobs, but indicating that modifications were necessary for some. Ms. Byers performed another labor market survey, and identified jobs that did not require standing or walking over six hours a day, or lifting more than five pounds. She noted that some of the original jobs fit that description (Tr. 181). These jobs are listed at Employer's Exhibit 48. She also wrote to the Claimant, with the list of additional jobs (Tr. 183, EX 45).

On September 17, 2002, Ms. Byers sent the Claimant a letter identifying eight jobs that were available for her (EX 45). Also on that date, Ms. Carrie Brinkley, of Ms. Byers' office, sent a letter to the Employer's attorney, indicating that she had received a call from the Claimant on September 13, returning Ms. Byers' calls. The Claimant did not understand why Ms. Byers was contacting her, as she had received documentation stating that she was totally disabled. She told Ms. Byers that she did not see any reason that she needed to talk to her about work related issues (Tr. 187).

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appointment for September 13, 2002, by calling and leaving a message for the Claimant on September 11. The Claimant called on September 13 and left a message with Ms. Byers' assistant, stating that she did not need to meet with Ms. Byers because she had been found totally disabled, and she did not want to waste Ms. Byers' time. The Claimant indicated that she was not available any time that day, even for a telephone call. Finally, Ms. Byers spoke to the Claimant when she called on September 19, and the Claimant told her that there was no need to meet because she was totally disabled.

On September 25, 2002, Ms. Byers wrote to the Employer's attorney, indicating that the Claimant's wage earning capacity was $7.50 to $10.00 an hour, based on currently available jobs EX 49). She indicated that wages for these jobs had not changed since 2000, and that the types of jobs listed on the labor market survey chart were regularly available in the Claimant's labor market.

II. Stipulations

The parties entered into the following stipulations at the hearing:

A. The Claimant's claims are subject to the jurisdiction of the Act.

B. Claimant and Employer were in an employer/employee relationship at the time of the alleged incidents.

C. Claimant was injured in the course and scope of her employment on August 13, 1998 and June 20, 2000.

D. Timely notice was given to Employer concerning the alleged May 19, 1999 and June 20, 2000 injury.

E. Claimant was paid temporary total disability from May 23, 1999 through May 31, 1999, based on an average weekly wage of $301.80.

III. Issues

The issues for adjudication are:

A. Whether the Claimant suffered an accidental injury in the course and scope of her employment on May 19, 1999 and June 1, 1999.

II. If so, the nature and extent of Claimant's disability.

III. The nature and extent of the Claimant's disability as a result of her August 13, 1998 and June 20, 2000 injuries.

IV. Whether the Claimant's psychiatric condition is work-related.

V. Whether the Employer is entitled to §8(f) relief.

III. Findings of Fact and Conclusions of Law

A. Existence of a work-related injury

"It is well-established that an administrative law judge is entitled to evaluate the credibility of all witnesses and to draw his own inferences from the evidence." *Wendler v. American National Red Cross,* 23 BRBS 408, 412 (1990). It is also well-established that the administrative law judge is not bound to accept the opinion or theory of any particular medical examiner. *Hite v. Dresser Guiberson Pumping,* 22 BRBS 87, 91 (1989).

The Act provides a presumption that a claim comes within its provisions. *See,* 33 U.S.C. § 920(a). This presumption "applies as much to the nexus between an employee's malady and his employment activities as it does to any other aspect of a claim." *Swinton v. J. Frank Kelly, Inc.,* 554 F.2d 1075 (D.C. Cir. 1976), *cert. denied,* 429 U.S. 820 (1976). The Claimant's uncontradicted credible testimony alone may constitute sufficient proof of physical injury. *Golden v. Eller & Co.,* 8 BRBS 846 (1978), *aff'd,* 620 F.2d 71 (5th Cir. 1980); *Hampton v. Bethlehem Steel Corp.,* 24 BRBS 141 (1990); *Anderson v. Todd Shipyards, supra,* at 21; *Miranda v. Excavation Construction, Inc.,* 13 BRBS 882 (1981).

However, this statutory presumption does not dispense with the requirement that a claim of injury must be made in the first instance, nor is it a substitute for the testimony necessary to establish a "prima facie" case. The Supreme Court has held that "[a] prima facie 'claim for compensation,' to which the statutory presumption refers, must at least allege an injury that arose in the course of employment as well as out of employment." *United States Indus./Fed Sheet Metal, Inc., v. Director, Office of Workers' Compensation Programs, U.S. Dept. Of Labor,* 455 U.S. 608, 615 (1982). Moreover, "the mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." *Id.* The presumption, though, is applicable once the claimant establishes that he has sustained an injury, i.e., harm to his body. *Preziosi v. Controlled Industries,* 22 BRBS 468, 470 (1989); *Brown v. Pacific Dry Dock Industries,* 22 BRBS 284, 285 (1989); *Trask v. Lockheed Shipbuilding and Construction Company,* 17 BRBS 56, 59 (1985); *Kelaita v. Triple A. Machine Shop,* 13 BRBS 326 (1981).

To establish a prima facie claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that (1) the claimant sustained physical harm or pain and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. Once this prima facie case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. To rebut the presumption, the party opposing entitlement must present substantial evidence proving the absence of or severing the connection between such harm and employment or working conditions. *Parsons Corp. of California v. Director, OWCP,* 619 F.2d 38 (9th Cir. 1980); *Butler v. District Parking Management Co.,* 363 F.2d 682 (D.C. Cir. 1966); *Ranks v. Bath Iron Works Corp.,* 22 BRBS 301, 305 (1989. Once the claimant establishes a physical harm and working conditions which could have caused or aggravated the harm or pain the burden shifts to the employer to establish that the Claimant's condition was not caused or aggravated by his employment.

Although the Claimant originally alleged four separate work-related injuries, denoted by four separate OWCP claim numbers, it appears that there are actually only three injuries at issue.[13] The Claimant did not describe a June 1, 1999 injury in her deposition or hearing testimony, and her attorney indicated in his prehearing submission that the designation of a June 1, 1999 date of injury was an administrative error at OWCP. Nor are there any treatment notes, contemporaneous or otherwise, that reflect a June 1, 1999 injury, and the Claimant did not mention such an injury when she was at the occupational health clinic on June 4, 1999. While the Employer agrees that the Claimant suffered work-related injuries on August 13, 1998, and June 20, 2000, it argues that the Claimant has not established that she suffered work-related injuries on May 19, 1999 or June 1, 1999. Based on the evidence in the record, I find that the Claimant has established a prima facie case for compensation for a May 19, 1999 injury, but that the Claimant does not allege, and the evidence does not support a conclusion, that there was a June 1, 1999 injury.

The records from the occupational health clinic reflect that the Claimant sought treatment on May 19, 1999 for an injury she suffered while taking a dolly down a stairway. This contemporaneous report is consistent with the Claimant's testimony, which I found to be credible on this issue, and I find that the Claimant has established a prima facie case that she suffered work-related injuries on that date. However, there is no evidence to support a finding that the Claimant suffered a work related injury on June 1, 1999, and the Claimant apparently has conceded that she did not.

The Employer argues that the Claimant's claim for compensation for her August 13, 1998 injury is time barred, because she did not report it to the Employer in a timely fashion. Under Section 12(a), an employee in a traumatic injury case is required to notify the employer of her work-related injury within 30 days after the date of injury or the time when the employee was aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the injury and the employment. *Bivens v. Newport News Shipbuilding & Dry Dock Co.*, 23 BRBS 233 (1990). *See Sheek v. General Dynamics Corp.*, 18 BRBS 1 (1985), *on recon.*, 18 BRBS 151 (1986). Failure to provide timely notice as required by Section 12(a) bars the claim, unless excused under Section 12(d). Under Section 12(d), failure to provide timely written notice will not bar the claim if the claimant shows either that the employer had knowledge of the injury during the filing period (Section 12(d)(1)) or that the employer was not prejudiced by the failure to give timely notice (Section 12(d)(2)). *See Addison v. Ryan-Walsh Stevedoring Co.*, 22 BRBS 32, 34 (1989).

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[13] Further confusing the issue is the Employer's First Report of Injury, dated April 9, 2001, reflecting that the Claimant had an on the job injury on June 6, 2000 (EX 12). The Claimant testified in her deposition and at the hearing that she injured her back lifting a bag of quarters on June 6, 2000. However, the Claimant never filed a claim for an injury of that date, nor did her attorney address it in his closing brief.

The Employer has submitted an affidavit by Tracie True, the adjuster responsible for the Claimant's injury files, stating that the Claimant submitted a handwritten statement regarding the August 13, 1998 injury on October 6, 1999 (EX 47). Ms. True also stated that the Claimant's failure to notify the Employer within thirty days of the injury severely prejudiced the Employer, because it was precluded from conducting a timely investigation into the circumstances of the alleged injuries, including obtaining a timely medical examination. The Claimant testified that she told her supervisor, Memphis Hickman, about this injury, but that no one ever told her to do anything else about it. There is no corroboration for the Claimant's claim, from Mr. Hickman or anyone else.[14] The Claimant was clearly aware of the relationship between her injury and her employment, yet she did not notify the Employer until more than a year later. Nor is there any evidence in the record that the Employer had actual knowledge of the injury during the filing period. The Employer argues that it was prejudiced, in that it did not have the opportunity to investigate and have the Claimant treated by physicians of its choosing. I find that the Claimant's claim for compensation for her August 13, 1998 injury is time-barred, as there is no evidence either that the Claimant filed written notice of her work-related injury within the thirty day period, or that the Employer had actual knowledge that she had suffered a work-related injury, and the Employer was prejudiced by the Claimant's failure to notify it of the alleged injury.

B. Nature and Extent of Disability

The parties have stipulated that Claimant was injured in a work-related accident on June 20, 2000.[15] Having established an injury, the Claimant bears the burden to prove the nature and extent of her disability. *Trask v. Lockheed Shipbuilding Construction Co.*, 17 BRBS 56, 59 (1985). A claimant's disability is permanent in nature if she has any residual disability after reaching maximum medical improvement (MMI). The determination of when maximum medical improvement is reached so that a claimant's disability may be said to be permanent is primarily a question of fact based on medical evidence. *Lozada v. Director, OWCP,* 903 F.2d 168, 23 BRBS 78 (CRT) (2nd Cir. 1990); *Hite v. Dresser Guiberson Pumping,* 22 BRBS 87, 91 (1989).

The question of extent of disability is an economic as well as medical concept. *Quick v. Martin,* 397 F.2d 644 (D.C. Cir. 1968); *Eastern S.S. Lines v. Monahan,* 110 F.2d 840 (1st Cir. 1940). A claimant who shows that she is unable to return to her former employment establishes a

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[14] The fact that the Claimant's supervisors reported her May 19, 1999 and June 20, 2000 injuries suggests that the supervisors were aware of the requirement and procedure for reporting work-related accidents, and casts doubt on the Claimant's claim that she told them that she had suffered a *work related* injury.

[15] Other than establishing dates for commencement of benefits, and possibly affecting the Employer's request for Section 8(f) relief, it is irrelevant whether there were one or four discrete injuries, as all relate to the same type of injury or aggravation, that is, lower back pain. In other words, even if I were to find that the Claimant's August 13, 1998 injury was not time-barred, it would not change my conclusions herein.

prima facie case for total disability. The burden then shifts to the employer to show the existence of suitable alternative employment. *P & M Crane v. Hayes*, 930 F.2d 424, 430 (5th Cir. 1991); *N.O. (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038, 14 BRBS 1566 (5th Cir. 1981). Furthermore, a claimant who establishes an inability to return to her usual employment is entitled to an award of total disability compensation until the date on which the employer demonstrates the availability of suitable alternative employment. *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128 (1991).

I find that the Claimant has failed to prove that her May 19, 1999 injury has rendered her disabled in any way, or that she is unable to return to her former employment due to that injury. The Claimant was initially treated at the Cherry Point Naval Hospital for this injury, but the x-ray showed no evidence of fracture or subluxation, and disc spaces were intact. There is no indication that the Claimant was advised to stay off work.[16] The Claimant was also treated by Dr. Gray at the Carteret Urgent Care Center beginning in July 1999. She was prescribed pain medication, home exercises, and the use of ice, and given a steroid injection. But there is no indication that she was advised to stay off work because of that injury.[17]

The Claimant also began treatment by Dr. Pettis, a chiropractor, in July 1999. Subsequently, Dr. Pettis kept the Claimant out of work for several periods of time. The Claimant's x-ray showed fact arthrosis at L4/.L5 and L5/S1, and spondylosis at L3 and L4. According to Dr. Nelson, facet arthrosis is otherwise known as arthritis, and it is the cause of any long term pain suffered by the Claimant. Dr. Pettis also referred to abnormal dermatomal evoked potential studies, which Dr. Nelson has described as unaccepted in the medical community, and inconsistent with the Claimant's symptoms. Indeed, the reports from Family Medical Care, where Dr. Pettis practices, have no specific diagnosis of any medical condition, supported by objective medical evidence. Finally, the Claimant told Dr. Pettis that her lower back and sciatic nerve pain began on July 15, 1999. I find that there is no reliable evidence that the Claimant's May 19, 1999 injury rendered her unable to return to her regular employment.

I find that the Claimant has failed to prove that her June 20, 2000 injury has rendered her disabled in any way, or that she is unable to return to her former employment due to that injury.[18]

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[16] It appears that the Claimant did stay off work, and was paid temporary total disability by the Employer until May 31, 1999 (EX 11).

[17] Ms. Vickers, Dr. Gray's former nurse practitioner, prepared a note in June 2001 indicating that the Claimant could do only light duty work. I do not give any credence to these restrictions, as Ms. Vickers is not a physician, nor does she offer any objective medical support for her statements.

[18] Even if I were to consider the other two injuries alleged by the Claimant, I would find that she has not established that she is not able to return to her regular job as a result of those injuries.

The medical evidence does not support the conclusion that the Claimant suffers from a disability related to this injury. In making this finding, I am relying on the reports by Dr. Nelson, Dr. Langley, Dr. Delaney, and Dr. Rollins. I specifically do not rely on the opinions of Dr. Nunn.[19]

Dr. Nunn testified that he is licensed to practice as a psychiatrist and an osteopath, and that he is board certified in psychology. His resume reflects that he received a masters degree in science and clinical counseling psychology in 1986, and a doctor of osteopathy degree in 1991, and that he completed an internship in internal medicine and psychiatry in 1995. Although his resume indicates that he is a member of the American Medical Association, the American Psychiatric Association, and the American Osteopathic Association, it does not reflect that he is board certified in any field. His medical license indicates only that he is properly licensed as a physician in North Carolina. Dr. Nunn is the owner of the Community Wellness Center.[20]

Dr. Nunn described osteopathy as the practice of holistic medicine, working with the patient's mind and body, and specializing in chronic pain and injuries to the musculoskeletal system. His treatments of the Claimant have consisted of "myofascial release," a set of massage techniques similar to, but more expansive than, those used by chiropractors. His opinion that the Claimant has a musculoskeletal injury to the lumbar region, which is a permanent myofascial injury, is based primarily on the Claimant's descriptions of pain, but also on the Claimant's ambulatory dysfunction, muscle spasms, or tightness, and his observations of the Claimant, which he stated were consistent with the small lateral disc herniation shown on the February 2002 MRI. There is no indication that he ever performed any kind of testing on the Claimant, such as range of motion, straight or seated leg raising, or any other types of motor testing or maneuvers that would have provided objective findings.

In completing the questionnaire used by the Social Security Administration, Dr. Nunn listed the Claimant's work restrictions, and also noted that she could not work at all because of her pain. Although the form asked for objective findings to support his conclusions, he provided none, and it appears that the Claimant's subjective complaints of pain are the only basis for his comments on that form.

On the other hand, Dr. Nelson, a board certified orthopaedic surgeon, conducted a normal examination of the Claimant, and found that she was neurologically intact. Although he noted exaggerated pain response by the Claimant, he felt that she would need further medical care, and

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[19] The Claimant saw Dr. Gray at the Carteret Urgent Care Center on June 22, 2000, and was diagnosed with exacerbation of lumbosacral strain. She was similarly diagnosed on July 22, 2000. However, other than continuing the Claimant's medications, there is no indication that the Claimant's condition kept her from returning to work.

[20] Although I am not making a finding of bias on Dr. Nunn's part on this basis, I note that his ownership of the Community Wellness Center, where the Claimant continues to be treated, provides him with a financial motivation that Dr. Nelson and Dr. Rollins do not have.

work restrictions to be documented by an FCE. During the FCE, the Claimant also exhibited inappropriate behavior and positive symptom magnification. The restrictions obtained at that evaluation were the least that the Claimant could perform, and it was recommended that she return to work with restrictions, and a gradual return to duty over a two to four week period. Dr. Nelson stated that the small lateral disc herniation at L3/L4 on the right was not significant, and in any event did not correlate to the Claimant's symptoms. He discounted the dermatomal evoked potential tests performed by Dr. Pettis as not well-accepted, and in any event showing peripheral neuropathy that was not of spinal origin. He felt that the Claimant could work, even using the invalid FCE results.

Dr. Langley also reported that the Claimant did not cooperate with his motor testing. Nevertheless, there was normal range of low back motion, with only subjective tenderness over the lumbar muscles, and no muscle spasm or spine tenderness. Straight leg raising was negative, the Claimant's leg lengths were equal, and there was no atrophy. Dr. Langley found no deficit in the lower extremities, and normal painless range of hip, knee, ankle, and foot motion bilaterally. Although he felt that there was no objective evidence of impairment that would prevent the Claimant from returning to work at full duty, he felt that she would need continued conservative support for her depression and chronic back pain. He noted that the Claimant seemed happy with her restricted work of limited lifting.

Dr. Delaney, who is a board certified physiatrist, also examined the Claimant at Dr. Gray's request, and noted symmetrical muscle development with no evidence of disuse atrophy. His examination was normal, and her range of motion was within functional limits. He also reviewed the Claimant's February 2000 MRI. He did not find any specific neurologic dysfunction or any evidence of disc herniation or significant arthritis, although there was evidence of chronic degenerative changes not associated with trauma. He felt that the Claimant had chronic pain syndrome without associated anatomic abnormality, and that it was appropriate for her to return to work as tolerated.

The assessments by Dr. Nelson, Dr. Langley, and Dr. Delaney were confirmed by Dr. Rollins, who concluded that the Claimant suffers from bereavement, due to the loss of her parents and relationships. He indicated that her symptom complex could also be diagnosed as depressive order, or as a pain disorder with psychological factors. He did not feel that the Claimant's psychiatric disorder was the result of either 1999 or 2000 injuries. He also felt that there were jobs that the Claimant could do, and that she has no psychiatric work restrictions. He specifically reviewed and approved the job descriptions of janitor, office assistant, sales representative, store manager, assistant manager, and courier/messenger.

I note that Dr. Nunn is the only medical person who has indicated that the Claimant is unable to return to her regular duties. It would be possible to infer such a conclusion from the restrictions and modifications approved by Dr. Nelson in connection with the labor market survey. However, I note that these restrictions were based on the results of the invalid FCE, which determined only the minimum that the Claimant was capable of performing.

Although Dr. Nunn describes himself as a psychiatrist on his treatment notes, there is nothing in the Claimant's treatment notes to indicate that he ever conducted an evaluation of her mental status, and indeed he was only marginally aware of the stressful factors in her life, which are nowhere reflected in his notes. Nor is there any indication that he has treated the Claimant for anything other than physical complaints. I find that his opinion, that the Claimant's depression is the result of her pain, is not supported by objective medical evidence, and is not reliable.

Dr. Rollins is board certified in psychiatry, and the subspecialty of forensic psychiatry, as well as independent medical examination and pain medicine. According to Dr. Rollins, the Claimant's bereavement and depression disorders are not due to her work-related injuries, although they may contribute to her perception of pain. But even if they were, Dr. Rollins stated that they would not prevent her from performing work suitable to her physical capabilities.

Based on the superior qualifications of Dr. Langley, Dr. Nelson, Dr. Delaney, and Dr. Rollins, as well as the fact that their conclusions are based on objective findings, or, in this case, the total lack of objective findings, I give determinative weight to their conclusions.

Finally, even if I were to determine that the Claimant could not return to her regular duties, whether as a result of one or a combination of the injuries she alleges, I find that the Employer has more than adequately established the existence of suitable alternative employment for the Claimant, with no loss in wage earning capacity. Ms. Byers, the vocational expert retained by the Employer, identified eight specific jobs that were within the Claimant's educational and physical capabilities. She reviewed the reports of Dr. Nelson, Dr. Langley, Dr. Gray, and Dr. Nunn, and relied on the physical restrictions as set out in the Claimant's functional capacity evaluation. It is worth noting that the results of this evaluation represent the minimal level of the Claimant's capabilities, as it was determined to be invalid due to the Claimant's poor effort and cooperation. Nevertheless, Ms. Byers was able to identify eight employers who were willing to consider the Claimant with those restrictions, and she described the precise nature, terms, and availability of those jobs in her report.

Dr. Nelson reviewed these positions, and suggested modifications; Ms. Byers then identified the positions that were consistent with these modifications, which included some of the original positions she had identified, and sent them to the Claimant. The Claimant did not contact any of these employers, and indeed told Ms. Byers' associate that she did not think she was required to look for a job, because she had already been determined to be disabled.[21] Indeed, the only effort the Claimant has made to find employment was in satisfying the minimal requirements

[21] Apparently, the Claimant was referring to the determination of total disability from the Social Security Administration. Of course, this finding is not binding on this Court; I note that it was based on Dr. Nunn's records and restrictions, which are discussed above.

for seeking employment in connection with her unemployment benefits in January 2001.[22]

I find that the Employer established that there were jobs realistically available to the Claimant, that she could secure and perform if she diligently sought employment.[23] These jobs, which pay between $7.50 and $10.00 an hour, or $300 to $400 a week, are at or above the Claimant's average weekly wage, and thus she has suffered no loss in wage earning capacity.[24] It is not necessary, as suggested by the Claimant in her posthearing brief, for the Employer to establish that a job was actually offered to the Claimant. (Brief for Claimant at 11). Indeed, it would be difficult for the Claimant to be offered a job when she did not apply for any of the positions identified by Ms. Byers. Ms. Byers also testified that these jobs, with the same hourly wage, were available in 2000.

The Employer paid the Claimant temporary total disability benefits from May 23, 1999 through May 31, 1999. The Claimant requests continuing temporary total disability benefits, from July 27, 2000 to March 4, 2002. As discussed above, I discount the opinions of Dr. Pettis as unsupported by objective medical evidence, and I find that the Claimant had no continuing disability from her May 19, 1999 injury. With respect to the Claimant's June 20, 2000 injury, Dr. Nunn is the only physician who has suggested that the Claimant cannot return to work. However, I have also discounted his opinions for the reasons discussed above. The Claimant saw Dr. Gray in mid-July 2000, but the treatment notes merely reflect that her medications were continued; they do not reflect that the Claimant was advised to stay out of work. There is no credible evidence to establish that the Claimant was not physically able to work after July 27, 2000.[25] Thus, I find that the Claimant has not established that she was unable to return to work due to any work-related injury.

Finally, the Claimant requests that, if I find that the Employer has established the existence of suitable alternate employment, the jobs identified in the Employer's labor market survey be considered to be available as of March 14, 2000, the date of the survey. Ms. Byers, who is a licensed professional counselor, a nationally certified rehabilitation counselor, case manager, and vocational evaluator, and a Department of Labor rehabilitation counselor, testified that the jobs

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[22] I note that the Claimant has a strong incentive not to look for work, because if she were to become employed, it could jeopardize her award of Social Security disability benefits.

[23] Although the date of Ms. Byers' labor market survey was March 14, 2002, she testified that the same types of jobs had been available, at the same pay rate, since 2000.

[24] Although the parties did not stipulate to the Claimant's average weekly wage, the Claimant's counsel indicated that it is $301.80.

[25] Coincidentally, the Claimant received a notice, dated July 10, 2000, that the vending operation was being contracted out, and her job would be abolished as of August 1, 2000 (EX 10).

she identified were regularly available in the Claimant's labor market, with the same wages during the year 2000. Given Ms. Byers' credentials, as well as her thorough review of the Claimant's capabilities and the positions available to her, I find that the Employer has established that suitable alternate employment existed for the Claimant in the year 2000.[26]

IV. Conclusion

I find that the Claimant has established a prima facie claim for compensation with respect to her May 19, 1999 and her June 20, 2000 injuries. I also find that the Claimant has not established that she suffered any disability, whether temporary, permanent, total, or partial, as a result of these injuries. But even if she had established that she was unable to return to her regular job as a result of these injuries, I find that the Employer has established the existence of suitable alternative employment, with no loss in wage earning capacity. Finally, I find that the Claimant has not established that her psychiatric condition is work-related; but even if she had, any restrictions do not impair her ability to perform the jobs identified by the Employer.

Accordingly, the Claimant's claim for benefits under the Act must be denied. As I have found that the Claimant has no permanent impairment as a result of work related injuries, it is unnecessary to address the Employer's request for Section 8(f) relief.

ORDER

In view of the foregoing, IT IS HEREBY ORDERED that the Claimant's claims for benefits under the Act in connection with alleged injuries of August 13, 1998, May 19, 1999, and June 20, 2000 are DENIED.

SO ORDERED.

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[26] *See, Newport News Shipbuilding & Dry Dock Co. v. Tann*, 841 F.2d 540, 21 BRBS 10 (4th Cir. 1988); *Jones v. Genco, Inc.*, 21 BRBS 12 (1988).

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LINDA S. CHAPMAN
Administrative Law Judge